Connections Family Therapy, LLC

Keri L Christensen LISW
1930 St Andrews Court NE, Cedar Rapids, IA 52402

Thank you for choosing Connections Family Therapy! Please complete the forms below. If the paperwork is not completed before the first session, you will be asked to stay after the intake session to complete the paperwork. This information is very helpful to have prior to beginning the first session. You will also be asked to show a photo ID and a copy of your insurance card, so please have these with you.

My office is located at 1930 St. Andrews Court NE, Suite T, Cedar Rapids. Turn off of Blairs Ferry Road at the sign for St. Andrews golf course. Once you enter the parking lot area, you will see 2 buildings that look very similar. I am in the building on the left that has the address 1930 on it. Enter the building on the east/right side. There is a St. Andrews crest near the door. Enter through that door and walk down the hall until you come to the end where you will find a waiting room. Have a seat and send me a text that says, “here” and I will come and get you at your appointment time.

You are responsible for contacting your insurance provider to obtain benefit information prior to the first appointment. If pre-certification is required by your insurance, you must obtain this prior to the session.

Thank you!

Keri

Office Policies and Agreement for Services

Therapy Services:
I use a diverse mixture of different types of therapy theories in session; however, therapy will be goal-directed and problem-focused. This means that a treatment goal(s) is established following a thorough assessment. The client will take an active role in therapy. Commitment to therapy is essential for the most successful outcome. You may request a referral for a different therapy at any time; however, you must first pay all outstanding bills. *Please inform me of any concerns you have regarding your therapy, so we can attempt to resolve these together*.

_________ (initials)

***Confidentiality*:**
Therapy is a place where you should feel safe and comfortable discussing difficult issues. The State of Iowa laws require that the majority of what is said in therapy be held in confidentiality. Parents do have the right to know the general content of therapy sessions for their minor children. Releases of Information will be used to give permission to communicate with other care providers, family members or friends as agreed upon by the client and their guardian if a minor.

Authorization to Release Information is NOT required in the following circumstances.
1) The client presents as a danger to themselves or someone else.
2) Child-abuse or Dependent adult abuse is **suspected**.
3) Billing purposes.
4) A court-ordered subpoena is presented.

________ (initials)

***Appointments*:**
A scheduled appointment is a contract between you and your therapist. In order for therapy to gain the highest level of effectiveness, appointments should be kept. If you are absolutely unable to keep your appointment, please give a 24 hour notice. Also, if you must cancel, it is best to reschedule promptly to get back into the therapist's schedule. Initialing this section grants the therapist permission to send a text message reminder for your scheduled appointment. Providing your e-mail address gives the therapist permission to communicate through e-mail.

Unless restricted by a third party payer, you may be billed for missed appointments. There is a $50 charge for cancelled appointments without a 24 hour notice. If there is a continuation of missed appointments, therapy may be referred to another therapy source. If you are billed a no-show charge, please pay before your next scheduled appointment.

_________ (initials)

Emergency Access:
I am not able to handle emergency calls at this time. Please contact either Abbe Center: 319-398-3562 or Foundation 2: 319-362-2174. If you are suicidal, please go to the emergency room at your nearest hospital (St. Luke's if under the age of 18).

___________ (initials)

***Insurance Coverage and Fees*:**

1) Payment for services is your responsibility. Only your primary insurance will be billed (except for Medicare/Medicaid). It is your responsibility to obtain prior authorization for treatment and pay co-pays
2) **Co-payments are expected at the time of service.**
3) The person who seeks therapy, either for himself/herself or for a minor, is responsible for payment. Parents are responsible for account payments for their minor child. Accounts unpaid after 90 days are subject to be released to collections. Clients will be billed for additional costs involved and a service charge of $20 will be added to their account if their account is released to collection.
4) If no session has been scheduled for 60 days, I will understand that our therapeutic relationship has ended, unless otherwise agreed upon. If you want to continue counseling after that time, all outstanding bills will need to be paid before your file may be re-opened.

Fees:

Intake Interview –	**$185**
Individual Therapy Session – 30 minutes	**$95**
Individual Therapy Session – 45 minutes	**$115**
Individual Therapy Session – 60 minutes	**$150**
Family Therapy Session –	**$150**
Returned Check fee –	**$25 per incident**

you may be charged for email or phone consultations, as well as completion of paperwork that requires more than 15 minutes of work. **$50/30 minutes

Court-related Activities - (2 hr. min.)	**$300 per hour for depositions**
	$115 per hour travel time

___________ (initials)

***Consent for Treatment*:**

I authorize and request my practitioner to carry out psychological treatment during the course of my treatment**.** I understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. I understand that therapy has both benefits and risks. Benefits include improvement in existing and new relationships, conflict resolution and identifying skills to deal with stressors. Possible risks include painful emotions arising from the discussion of difficult subjects as well as changes which could occur in relationships. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. I understand that if I am seeking therapy for my child that I am the legal guardian or legal representative and that the policies described in this statement apply to the patient that I represent.

___________ (initials)

I have read the policy statement and agree to the terms.

_______________________________ _______________________
Client/Guardian Signature Date

____
Printed Name

_______________________________ _______________________
Practitioner/Witness Signature Date

Informed Consent Form for Treatment

Acknowledgment and Authorization Form (#1): I hereby acknowledge that I was given the opportunity to read and to receive a copy of the Notice of Privacy Practices for Connections Family Therapy, LLC.

Authorization to Release Information to Insurance Carrier (#2): I hereby authorize Connections Family Therapy, LLC to furnish my insurance carrier all information required for processing claims. Such information typically includes identifying information (client's name, date of birth, insured's name and address, etc.), diagnosis, prognosis, progress, and treatment plan. I understand that I have the right to inspect any materials released to the insurance carrier.

I also authorize my insurance carrier to release any pertinent information regarding coverage, deductible, payments made, or any other information requested to clarify claims to Connections Family Therapy, LLC.

I further authorize photocopies to be made of this release and for the insurance company to accept the photocopies.

This authorization shall continue in force and effect until revoked in writing by me.

Authorization to Pay Supplier (#3): I hereby authorize payment of Medical Benefits and/or Mental Health Benefits to Connections Family Therapy, LLC for services rendered.

Authorization for Treatment (#4): I give Connections Family Therapy, LLC and Keri L Christensen, LISW consent to treat myself or my minor child.

Authorization for Collection (#5): I understand that if I fail to pay, the account can be turned over for collection and that I will be responsible for all costs involved.

I acknowledge and agree to the authorizations listed above (#1, 2, 3, 4, & 5).

____ ____________
Client / Insured Signature / Biological Parent or Legal Guardian Date

Please complete form on reverse side

Connections Family Therapy, LLC

Keri L Christensen LISW
1930 St Andrews Court NE, Cedar Rapids, IA 52402

Client
Name: Last ___________________________________ First __________________________ M.I.____
Address: ____________________________________ City:_________________________ Zip:_______
Home Phone: (_____) ____________________________ Cell: (_____) __________________________
SSN: ___________________________________ Gender: M or F Birth Date: _________________
Employer: _______________________________ Address: ____________________________________
Work Phone: (_____) ________________________

Spouse
Name: Last ____________________________________ First __________________________ M.I.____
Address: ____________________________________ City:_________________________ Zip:_______
Home Phone: (_____) ____________________________ Cell: (_____) __________________________
SSN: ___________________________________ Gender: M or F Birth Date: _________________
Employer: ________________________________ Address: ____________________________________
Work Phone: (_____) ________________________

When the client is a minor, please fill in the Mother's & Father's information.

Mother
Name: Last ___________________________________First ____________________________ M.I.____
Address: _____________________________________ City:__________________________Zip:_______
Home Phone: (_____) __________________________ Cell: (_____) ____________________________
SSN: ____ Birth Date: ______________________________
Employer: _________________________________Address: ___________________________________
Work Phone: (_____) ________________________

Father
Name: Last ___________________________________First ____________________________ M.I.____
Address: ____________________________________ City:_________________________ Zip:_______
Home Phone: (_____) ________________________ Cell: (_____) ______________________________
SSN: _____________________________________ Birth Date: _________________________________
Employer: ________________________________ Address: ____________________________________
Work Phone: (_____) ________________________

Emergency Contact (not spouse or parent)
Name: ____ Relationship: ______________________
Address: ____ Phone: ___________________________

Send Statement to and Responsible Party for Payment:
Name: ____ Relationship: ________________________
Address: ____ City: ______________________________
Phone: ____ Zip: _______________________________

Insurance:
Company: ____ Policy ID#: _____________________
Insured's name: _______________________________________ Group #: _______________________
Authorization #: ____________________________________ Number of Sessions: _________________
Dates of Authorization: From ___________ to _____________ Deductible: _________ Co-Pays: ______

I affirm that the above information is true: *Signed* ______________________________*date:* _______

Medical & Social History Form for Child/Adolescent

Child's Name: ____ Date: ________________
Address: ____
Date of Birth: ___________________________ Age: _____________ Race: _________________________
Name of Person completing this form: ____
Relationship to child: ______________________________ Referral Source: ___________________________

SCHOOL INFORMATION:
Child's School: ____ Grade: _________________________
Does this child receive Special Education Services (e.g., Chapter I, Resource Room, Tutoring) ______________
____
Does this child have an IEP?___________ Has this child ever repeated a grade? _________________________
School activities (e.g., sports, clubs): ____
Other community involvements (e.g., sports, Scouts, volunteering): _____________________________________
____
In general, describe this child's performance during elementary school. List strengths or problems. ___________
____
____
Describe this child's performance during middle school and high school. List strengths or problems. _________
____
____
Describe any problems with learning for this child. ____
____
____
Describe any social problems at school for this child. ____
____
____
Indicate if your child's teacher(s) describes any of the following as significant classroom problems.

___ Doesn't sit still in seat.
___ Shouts out.
___ Does not cooperate well in group activities.
___ Does not respect the rights of others.
___ Fails to finish assigned homework.
___ Wets / soils self.
___ Is not sought out by others to play or work together.
___ Frequently gets up and walks around the classroom.
___ Does not wait their turn to be called on.
___ Typically does better in a one to one relationship.
___ Does not pay attention during lessons.
___ Bullies other children.
___ Difficulty transitioning.

FAMILY INFORMATION:
Child's father's name: _______________________________ Employer:______________________________
Child's mother's name: ______________________________ Employer:______________________________
With whom does this child live? ____
Who has legal custody of this child? ____
Has this child ever had any placements outside of the home (e.g., DHS, foster care)? ______________________
Names and ages of siblings to this child: ____
____
Any recent stressors for the family (e.g., job loss, school change, relocation, death in family)? ______________
____
____

What does the child think about coming to therapy? ____
____
Describe any differences or similarities between each of the parent's management style in handling disruptive behavior:____
____

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HEALTH INFORMATION:

Physician: ____

Clinic location: ____

Has this child previously been in counseling? If so, when, where, and what were the issues?________________

____

____

Was that counseling satisfactory? Why or why not? ____

____

What is the current reason for seeking counseling? ____

____

Does this child have any major medical problems? If so, please describe: ______________________________

____

____

Any history of a major head injury, concussion, or loss of consciousness? ______________________________

____

Is this child currently taking any medications? If so, please state which ones, dosage, and how long they have been on them: ____

____

Previous medications prescribed for ADHD, mood, anxiety, or behavior? ______________________________

____

Have this child or a family member ever been hospitalized for emotional problems? If so, please explain when, where, and why: ____

____

Any known allergies for this child? ____

____

BEHAVIOR CHARACTERISTICS: (check all that CURRENTLY apply to your child)

___ Overactive / Fidgety	___ Inattentive	___ Under-active	___ Moody	___ Plays well
___ Accident prone	___ Stubborn	___ Destructive	___ Temper tantrums	___ Leader
___ Rebellious	___ Easily afraid	___ Sensitive	___ Shy	___Cooperative
___ Excitable	___ Impulsive	___ Cries easily	___ Easily angered	___Loner
___ Sad/Unhappy	___ Nervous/Worried	___ Follower	___ Mean to children	___Stealing
___ Happy/Cheerful	___ Mean to animals	___ Lying	___ Cheating	___Moody
___ Fire setting	___ Nail biting	___ Thumb sucking	___ Tics/Nervous habits	

ALCOHOL AND DRUG USE:

Do you have any concerns that this child may be using alcohol or drugs? If so, what are your concerns? ______

____

____

LEGAL INVOLVEMENT:

Has this child had any legal involvements (e.g., DHS, probation, juvenile placements)? ____________________

____

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